

		FOR OHF USE					

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2002  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2002)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0044750</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>																																																	
<b>Facility Name:</b> <u>COMMUNITY NURSING &amp; REHABILITATION CENTER</u>		<b>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2002</u> to <u>12/31/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</b>																																																	
<b>Address:</b> <u>1136 NORTH MILL STREET</u> <u>NAPERVILLE</u> <u>60563</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</b>																																																	
<b>County:</b> <u>DUPAGE</u>																																																			
<b>Telephone Number:</b> <u>(630) 355-3300</u> <b>Fax #</b> <u>(630) 355-1417</u>																																																			
<b>IDPA ID Number:</b> <u>3643458778001</u>																																																			
<b>Date of Initial License for Current Owners:</b> <u>04/01/2000</u>																																																			
<b>Type of Ownership:</b>																																																			
<table><tr><td><input type="checkbox"/></td><td>VOLUNTARY, NON-PROFIT</td><td><input checked="" type="checkbox"/></td><td>PROPRIETARY</td><td><input type="checkbox"/></td><td>GOVERNMENTAL</td></tr><tr><td><input type="checkbox"/></td><td>Charitable Corp.</td><td><input type="checkbox"/></td><td>Individual</td><td><input type="checkbox"/></td><td>State</td></tr><tr><td><input type="checkbox"/></td><td>Trust</td><td><input type="checkbox"/></td><td>Partnership</td><td><input type="checkbox"/></td><td>County</td></tr><tr><td colspan="2"><b>IRS Exemption Code</b> _____</td><td><input type="checkbox"/></td><td>Corporation</td><td><input type="checkbox"/></td><td>Other _____</td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>"Sub-S" Corp.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input checked="" type="checkbox"/></td><td>Limited Liability Co.</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Trust</td><td colspan="2"></td></tr><tr><td colspan="2"></td><td><input type="checkbox"/></td><td>Other _____</td><td colspan="2"></td></tr></table>		<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL	<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State	<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County	<b>IRS Exemption Code</b> _____		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	"Sub-S" Corp.					<input checked="" type="checkbox"/>	Limited Liability Co.					<input type="checkbox"/>	Trust					<input type="checkbox"/>	Other _____				
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		<input checked="" type="checkbox"/>	Limited Liability Co.																																																
		<input type="checkbox"/>	Trust																																																
		<input type="checkbox"/>	Other _____																																																
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>BOB KAGDA</u> <b>Telephone Number:</b> <u>( 847 ) 675-3585</u>																																																			
		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>MARK WELDLER</u> (Title) <u>CFO</u>																																																	
		<b>Paid Preparer</b> (Signed) <u>(SEE ATTACHED ACCOUNTANTS' REPORT)</u> (Date) _____ (Print Name and Title) <u>BOB KAGDA</u> <u>PARTNER</u> (Firm Name & Address) <u>KRUPNICK BOKOR KAGDA &amp; BROOKS, LTD</u> <u>3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124</u> (Telephone) <u>( 847 ) 675-3585</u> Fax # <u>( 847 ) 675-5777</u>																																																	
		<b>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</b>																																																	

Facility Name & ID Number COMMUNITY NURSING & REHABILITATION CENTER # 0044750 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>48</u>	Skilled (SNF)	<u>48</u>	<u>17,520</u>	1
2		Skilled Pediatric (SNF/PED)	<u>105</u>	<u>38,325</u>	2
3	<u>105</u>	Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>153</u>	TOTALS	<u>153</u>	<u>55,845</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,566</u>		<u>4,374</u>	<u>9,940</u>	8
9	SNF/PED					9
10	ICF	<u>25,361</u>	<u>11,044</u>		<u>36,405</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>30,927</u>	<u>11,044</u>	<u>4,374</u>	<u>46,345</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.99%

D. How many bed-hold days during this year were paid by Public Aid?  
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)  
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?  
YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?  
Date started 04/01/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES ☒ Date 04/01/2000 NO ☐

K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number of beds certified 48 and days of care provided 4,374

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002  
\* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **COMMUNITY NURSING & REHABILITATION** # **0044750** Report Period Beginning: **01/01/2002** Ending: **12/31/2002**  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	297,527	49,709	7,728	354,964		354,964		354,964			1
2	Food Purchase		241,547		241,547		241,547	(4,237)	237,310			2
3	Housekeeping	166,255	32,191		198,446		198,446		198,446			3
4	Laundry	34,597	18,342		52,939		52,939		52,939			4
5	Heat and Other Utilities			125,475	125,475		125,475		125,475			5
6	Maintenance	30,148	12,983	60,169	103,300		103,300	36,222	139,522			6
7	Other (specify):*			4,787	4,787		4,787		4,787			7
8	<b>TOTAL General Services</b>	528,527	354,772	198,159	1,081,458		1,081,458	31,985	1,113,443			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,534,306	146,525	52,602	2,733,433		2,733,433		2,733,433			10
10a	Therapy	38,486			38,486		38,486		38,486			10a
11	Activities	92,072	20,591		112,663		112,663		112,663			11
12	Social Services	39,342		182	39,524		39,524		39,524			12
13	Nurse Aide Training											13
14	Program Transportation			419	419		419		419			14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,704,206	167,116	89,203	2,960,525		2,960,525		2,960,525			16
	<b>C. General Administration</b>											
17	Administrative	130,833			130,833		130,833		130,833			17
18	Directors Fees											18
19	Professional Services			56,695	56,695		56,695		56,695			19
20	Dues, Fees, Subscriptions & Promotions			62,558	62,558		62,558	(43,774)	18,784			20
21	Clerical & General Office Expenses	128,374	29,093	30,273	187,740		187,740	200	187,940			21
22	Employee Benefits & Payroll Taxes			576,505	576,505		576,505		576,505			22
23	Inservice Training & Education			709	709		709		709			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation			1,858	1,858		1,858		1,858			25
26	Insurance-Prop.Liab.Malpractice			181,795	181,795		181,795		181,795			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	259,207	29,093	910,393	1,198,693		1,198,693	(43,574)	1,155,119			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	3,491,940	550,981	1,197,755	5,240,676		5,240,676	(11,589)	5,229,087			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			142,722	142,722		142,722	97,217	239,939			30
31	Amortization of Pre-Op. & Org.			600	600		600		600			31
32	Interest			34,479	34,479		34,479	276,749	311,228			32
33	Real Estate Taxes							109,404	109,404			33
34	Rent-Facility & Grounds			667,854	667,854		667,854	(667,854)				34
35	Rent-Equipment & Vehicles			37,614	37,614		37,614		37,614			35
36	Other (specify):*											36
37	TOTAL Ownership			883,269	883,269		883,269	(184,484)	698,785			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		181,651	242,106	423,757		423,757		423,757			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,772	83,772		83,772		83,772			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		181,651	325,878	507,529		507,529		507,529			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,491,940	732,632	2,406,902	6,631,474		6,631,474	(196,073)	6,435,401			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**      **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.**  
**In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,804)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,399)	30		9
10	Interest and Other Investment Income	(211)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,433)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(56)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers		19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(32,581)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(11,137)	20		28
29	Other-Attach Schedule <u>SEE PAGE 5A</u>	36,222			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (19,399)		\$	30

OHF USE ONLY							
48		49		50		51	

**B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)**

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(176,674)	PG 6	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (176,674)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (196,073)		37

**\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

**C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)**

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#0044750

Report Period Beginning:01/01/2002

Ending:12/31/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 36,222	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
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34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	36,222		49

## STATE OF ILLINOIS

Summary A

Facility Name & ID Number COMMUNITY NURSING & REHABILITATION CENTER# 0044750

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,237)	0	0	0	0	0	0	0	0	0	0	(4,237)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	36,222	0	0	0	0	0	0	0	0	0	0	36,222	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>31,985</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>31,985</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(43,774)	0	0	0	0	0	0	0	0	0	0	(43,774)	20
21	Clerical & General Office Expenses	0	200	0	0	0	0	0	0	0	0	0	200	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(43,774)</b>	<b>200</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(43,574)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(11,789)</b>	<b>200</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(11,589)</b>	<b>29</b>

## Summary B

**12/31/2002**

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MARK AND CHANA WELDLER	29.50%			COMMUNITY NURSING &		
STEVE AND BLUMA JEREMIAS	29.50%	WHEATON CARE CENTER	WHEATON	REHABILITATION REALTY		
MALKA MERMELSTEIN	0.50%	LAKEFRONT HEALTHCARE CENTER, INC.	CHICAGO	LLC	NAPERVILLE	REAL ESTATE
HERMAN MERMELSTEIN	0.50%					
JOSEPH NEUMANN	30.00%					
HIRSCH WOLF	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$	COMMUNITY NURSING & REHAB. REALTY, LLC		\$	\$	1
2	V	21	CLERICAL & GEN. OFFICE		"	100.00%	200	200	2
3	V	30	DEPRECIATION		"	100.00%	104,616	104,616	3
4	V	32	AMORTIZATION		"	100.00%	10,740	10,740	4
5	V	32	INTEREST EXPENSE		"	100.00%	266,220	266,220	5
6	V	33	PROPERTY TAXES		"	100.00%	109,404	109,404	6
7	V	34	RENT EXPENSE	667,854	"	100.00%		(667,854)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 667,854			\$ 491,180	\$ * (176,674)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	STEVE JEREMIAS	OWNER	ADMIN.	29.50%		50	100%	SALARY	\$ 80,000	17-3	1
2	MARK WELDLER	OWNER	ADMIN.	29.50%	25,000	50	100%	SALARY]	50,833	17-3	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 130,833		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number COMMUNITY NURSING & REHABILITATION CENT # 0044750 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization  
Street Address  
City / State / Zip Code  
Phone Number  
Fax Number

( )

( )

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
	1					\$	\$			1
	2									2
	3									3
	4									4
	5									5
	6									6
	7									7
	8									8
	9									9
	10									10
	11									11
	12									12
	13									13
	14									14
	15									15
	16									16
	17									17
	18									18
	19									19
	20									20
	21									21
	22									22
	23									23
	24									24
	25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7		8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense			
		YES	NO				Original	Balance						
	A. Directly Facility Related													
	Long-Term													
1	AMERICAN NATIONAL BNK		X	MORTGAGE	\$22,916.67	03/31/00	\$ 5,500,000	\$ 5,087,500	03/31/05	P+.0050	\$ 266,220	1		
2	MORTGAGE COST						53,702	24,167			10,740	2		
3												3		
4												4		
5												5		
	Working Capital													
6	AMERICAN NATIONAL BNK		X	WORKING CAPITAL	DEMAND	03/31/00	1,000,000	721,000		5.2500	34,479	6		
7												7		
8												8		
9	TOTAL Facility Related				\$22,916.67		\$ 6,553,702	\$ 5,832,667			\$ 311,439	9		
	B. Non-Facility Related*													
10												10		
11												11		
12												12		
13												13		
14	TOTAL Non-Facility Related						\$	\$			\$	14		
15	TOTALS (line 9+line14)						\$ 6,553,702	\$ 5,832,667			\$ 311,439	15		

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ Line #

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>			
1. Real Estate Tax accrual used on 2001 report.		\$ 96,536	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 109,400	2
3. Under or (over) accrual (line 2 minus line 1).		\$ 12,864	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 96,540	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 109,404	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1997	8	
	1998	9	
	1999	95,684	10
	2000	97,858	11
	2001	109,400	12
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL			
THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.			
		FOR OHF USE ONLY	
		13	FROM R. E. TAX STATEMENT FOR 2001 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    COMMUNITY NURSING & REHABILITATION CENTER    COUNTY    DUPAGE

FACILITY IDPH LICENSE NUMBER    0044750

CONTACT PERSON REGARDING THIS REPORT    BOB KAGDA

TELEPHONE    ( 847 ) 675-3585    FAX #:    ( 847 ) 675-5777

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	<u>07-12-403-042</u>	<u>NURSING HOME</u>	\$ <u>109,399.58</u>	\$ <u>109,399.58</u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>109,399.58</u>	\$ <u>109,399.58</u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?               YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

62,087

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒

YES

☐

NO

If so, please complete the following:

1. Total Amount Incurred:

3,000

2. Number of Years Over Which it is Being Amortized:

5 YEARS

3. Current Period Amortization:

600

4. Dates Incurred:

04/01/00

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	FACILITY	164,335				\$ 453,622	
2							
3	TOTALS	164,335				\$ 453,622	

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	153		2000	1986	\$ 4,184,589	\$ 104,616	40	\$ 104,616	\$	\$ 287,691	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	CABLE			2000	4,305	108	40	108		297	9
10	ELEVATOR DOOR			2000	4,389	110	40	110		293	10
11	PARKING LOT			2000	38,200	955	40	955		2,547	11
12	LANDSCAPING			2000	8,736	218	40	218		563	12
13	SIGN			2000	4,541	114	40	114		294	13
14	ARCHITECT FEES			2000	3,060	72	40	76	4	209	14
15	DOOR LOCK			2000	2,248	56	40	56		145	15
16	CLOSETS			2000	7,729	193	40	193		466	16
17	COVE BASE			2000	4,459	111	40	111		250	17
18	HANDRAILS AND KICKPLATES			2000	15,146	379	40	379		853	18
19	LIGHTING			2000	65,796	1,645	40	1,645		3,701	19
20	TILE			2000	2,317	58	40	58		130	20
21	FLOORING			2000	16,378	409	40	409		871	21
22	EXIT DOORS			2000	1,598	40	40	40		90	22
23	WINDOW AND CUBICLE TREATMENTS			2000	34,021	851	40	851		1,915	23
24	LIGHTING			2000	1,729	43	40	43		97	24
25	CARPETING			2000	27,139	678	40	678		1,526	25
26	FIRE PANEL			2000	4,500	113	40	113		254	26
27	NURSE'S STATION			2000	8,913	223	40	223		483	27
28	DOOR HANDLES			2000	1,644	41	40	41		89	28
29	CUBICLE TRACK			2000	915	23	40	23		48	29
30	MOTOR			2000	13,276	332	40	332		830	30
31	STOVE HOODS			2000	1,429	36	40	36		75	31
32	COVER BASE - RESIDENTS' TOOMS			2001	865	87	10	87		166	32
33	CERAMIC TILES			2001	10,930	1,093	10	1,093		2,095	33
34	CEILING & LIGHTING			2001	9,063	906	10	906		1,637	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	RENOVATIONS - THERAPY ROOM	2001	\$ 10,558	\$ 1,057	10	\$ 1,057	\$	\$ 2,025	37
38	TILE & COVE BASE - BASEMENT	2001	2,327	233	10	233		466	38
39	SHAMPOO STATION	2001	5,431	543	10	543		1,041	39
40	COVE BASE - SECOND FLOOR	2001	1,699	170	10	170		326	40
41	WALLPAPER/COVEBASE/CARPETING/LIGHTING	2001	1,403	140	10	140		269	41
42	ABS PUMP	2001	11,908	1,191	10	1,191		2,283	42
43	CARPETING	2001	14,572	1,457	10	1,457		2,793	43
44	FLOORING	2001	1,320	132	10	132		253	44
45	2ND FLOOR RENOVATIONS	2001	38,875	3,888	10	3,888		6,804	45
46	AVERY	2001	2,419	242	10	242		423	46
47	KITCHEN - COOLING AIR UNIT	2001	2,275	228	10	228		418	47
48	WALLCOVERINGS	2001	12,289	1,229	10	1,229		2,458	48
49	SIGNAGE/ELECTRIC BALLAST (ADMISSIONS OFFICE)	2001	3,131	313	10	313		522	49
50	ROOM CURTAIN DIVIDER	2001	2,003	200	10	200		334	50
51	HANDRAILS & BUMPER GUARDS	2001	17,855	1,786	10	1,786		2,976	51
52	FIRE ALARM TRANSFORMER	2001	1,715	172	10	172		286	52
53	TEMP CONTROL ON AIR HANDLER	2001	9,519	952	10	952		1,587	53
54	COVEBASE/LANDSCAPING/LIGHTING/FLOORING	2001	2,642	264	10	264		440	54
55	LIGHTING - CORRIDORS & RESIDENT ROOMS	2001	20,544	2,054	10	2,054		3,252	55
56	NEW BEARING & SHAFT	2001	1,402	140	10	140		210	56
57	DIALYSIS ROOM RENOVATIONS	2001	23,351	2,335	10	2,335		2,530	57
58	ASPHALT SEALCOATING & STRIPING	2001	1,405	141	10	141		188	58
59	KITCHEN TILE	2001	930	93	10	93		116	59
60	SEPTIC TANK PUMPS	2001	13,862	1,386	10	1,386		1,733	60
61	CARPETING	2001	5,729	573	10	573		907	61
62	PAINTING & WALLPAPER	2001	20,440	2,044	10	2,044		4,088	62
63	PAINTING & WALLPAPER	2001	11,875	1,188	10	1,188		2,079	63
64	PAINTING & WALLPAPER	2001	4,500	450	10	450		713	64
65	NEW DOORS	2002	1,731	87	10	87		87	65
66	MURAL FOR SECOND FLOOR DINING ROOM	2002	7,000	350	10	350		350	66
67	NEW TROUGH IN LAUNDRY ROOM	2002	6,300	315	10	315		315	67
68	WINDOW MOLDINGS	2002	210	11	10	11		11	68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,739,135	\$ 138,874		\$ 138,878	\$ 4	\$ 349,898	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$4,739,135	\$138,874		\$138,878	\$4	\$349,898	1
2									2
3	NEW THRESHHOLDS	2002	205	10	10	10		10	3
4	NEW PVC PIPING IN KITCHEN	2002	1,320	66	10	66		66	4
5	UPGRADE BACKFLOW SYSTEM	2002	1,695	85	10	85		85	5
6	ALARM FOR RAMP EXIT	2002	1,443	72	10	72		72	6
7	FLOORING IN ELEVATOR	2002	856	43	10	43		43	7
8	CORNER GUARDS/WATER SOFTENER	2002	1,328	66	10	66		66	8
9	NEW DRAINAGE PIPES - DISPOSAL	2002	9,985	499	10	499		499	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,755,967	\$139,715		\$139,719	\$4	\$350,739	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$990,047	\$106,164	\$99,004	\$(7,160)	10 YRS	\$271,726	71
72	Current Year Purchases	11,303	808	565	(243)	10 YRS	565	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$1,001,350	\$106,972	\$99,569	\$(7,403)		\$272,291	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1988 FORD ECONOLINE		\$	\$	\$	\$		\$	76
77		BUS	2000	3,255	651	651			1,790	77
78										78
79										79
80	TOTALS			\$3,255	\$651	\$651	\$		\$1,790	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,214,194	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$247,338	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$239,939	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$(7,399)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$624,820	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:      N/A-RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.      ☐ YES      ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning                            
Ending                          

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>                    </u> /2003	\$ <u>                    </u>
13.	<u>                    </u> /2004	\$ <u>                    </u>
14.	<u>                    </u> /2005	\$ <u>                    </u>

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                           .
9. Option to Buy:      ☐ YES      ☐ NO      Terms:                           \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?      ☐ YES      ☒ NO
16. Rental Amount for movable equipment:      \$ 30,256      Description:      SEE SCHEDULE ATTACHED  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>ADMINISTRATIVE</u>	<u>1999 ACURA</u>	\$ <u>579.00</u>	\$ <u>7,358</u>	17
18					18
19					19
20					20
21	TOTAL		\$ <u>579.00</u>	\$ <u>7,358</u>	21

\* If there is an option to buy the building,  
please provide complete details on attached  
schedule.

\*\* This amount plus any amortization of lease  
expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 22,104	\$		\$ 22,104	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			14,346			14,346	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			205,656			205,656	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescripts				180,659		180,659	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39-3					992		992	13
14	TOTAL			\$		\$ 242,106	\$ 181,651		\$ 423,757	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number **COMMUNITY NURSING & REHABILITATION CENTER** # **0044750** Report Period Beginning: **01/01/2002** Ending: **12/31/2002**  
**XV. BALANCE SHEET - Unrestricted Operating Fund.** As of **12/31/2002** (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 418,141	\$ 422,951	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	1,453,043	1,453,043	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	147,042	147,042	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 2,018,226	\$ 2,023,036	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost		4,184,589	14
15	Leasehold Improvements, at Historical Cost	680,040	680,040	15
16	Equipment, at Historical Cost	1,004,604	1,004,604	16
17	Accumulated Depreciation (book methods)	(348,475)	(636,168)	17
18	Deferred Charges		24,167	18
19	Organization & Pre-Operating Costs	3,000	3,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(1,650)	(1,650)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,337,519	\$ 5,712,204	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 3,355,745	\$ 7,735,240	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 595,169	\$ 595,169	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	229,712	229,712	28
29	Short-Term Notes Payable	2,270,150	1,121,000	29
30	Accrued Salaries Payable	43,272	43,272	30
31	Accrued Taxes Payable (excluding real estate taxes)	43,511	43,511	31
32	Accrued Real Estate Taxes(Sch.IX-B)		96,540	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36				36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 3,181,814	\$ 2,129,204	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,087,500	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$ 5,087,500	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 3,181,814	\$ 7,216,704	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 173,931	\$ 518,536	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 3,355,745	\$ 7,735,240	48

\*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 329,195	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 329,195	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(155,264)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (155,264)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 173,931	24 *

\* This must agree with page 17, line 47.



**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,343,066	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,343,066	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	131,687	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 131,687	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	177	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	1,280	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 1,457	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28			28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,476,210	30

2			
	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,081,458	31
32	Health Care	2,960,525	32
33	General Administration	1,198,693	33
	<b>B. Capital Expense</b>		
34	Ownership	883,269	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	423,757	35
36	Provider Participation Fee	83,772	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 6,631,474	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(155,264)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (155,264)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.  
TAX RETURN PREPARED ON CASH BASIS

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,842	2,050	\$ 71,114	\$ 34.69	1
2	Assistant Director of Nursing	4,287	4,519	39,178	8.67	2
3	Registered Nurses	28,298	30,063	732,574	24.37	3
4	Licensed Practical Nurses	15,541	16,342	405,521	24.81	4
5	Nurse Aides & Orderlies	74,323	80,059	1,161,665	14.51	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,628	6,145	38,486	6.26	8
9	Activity Director	1,938	2,104	29,773	14.15	9
10	Activity Assistants	7,803	8,077	62,299	7.71	10
11	Social Service Workers	1,952	2,080	39,342	18.91	11
12	Dietician					12
13	Food Service Supervisor	5,832	6,470	96,303	14.88	13
14	Head Cook	7,812	8,552	102,077	11.94	14
15	Cook Helpers/Assistants	13,689	14,310	99,147	6.93	15
16	Dishwashers					16
17	Maintenance Workers	2,253	2,611	30,148	11.55	17
18	Housekeepers	18,773	20,464	166,255	8.12	18
19	Laundry	4,354	4,715	34,597	7.34	19
20	Administrator	2,600	2,600	130,833	50.32	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,453	7,950	128,374	16.15	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,545	2,784	44,364	15.94	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Care Plan Coor</u>	6,289	6,672	79,890	11.97	33
34	TOTAL (lines 1 - 33)	213,212	228,567	\$ 3,491,940 *	\$ 15.28	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	189	\$ 7,728	1-3	35
36	Medical Director	MONTHLY	36,000	9-3	36
37	Medical Records Consultant	MONTHLY	555	10-3	37
38	Nurse Consultant		0	10-3	38
39	Pharmacist Consultant		0	10-3	39
40	Physical Therapy Consultant		0	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant		0	11-3	44
45	Social Service Consultant	MONTHLY	182	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	189	\$ 44,465		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	1,887	\$ 49,058	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	1,887	\$ 49,058		53

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT/DECORATING	09/2000	\$ 108,663		\$	\$ 18,110	\$ 36,221	\$ 36,222	\$ 18,110	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 108,663		\$	\$ 18,110	\$ 36,221	\$ 36,222	\$ 18,110	\$	\$	\$	\$

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

YES

If YES, give association name and amount.

ILL. COUNCIL FOR LTC - \$9653

(3) Did the nursing home make political contributions or payments to a political action organization?

NO

If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YR

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

Line

10-2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

N/A

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$

83,772

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

#REF!

Has any meal income been offset against related costs?

Indicate the amount.

\$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

c. What percent of all travel expense relates to transportation of nurses and patients?

10%

d. Have vehicle usage logs been maintained?

ADEQUATE LOGS ARE MAINTAINED

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

YES

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

N/A

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

N/A

(17) Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

YES

Attach invoices and a summary of services for all architect and appraisal fees.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	<b>DIETARY</b>	
	DIETITIAN CONSULTANT XVIII B 35-2	7,728
	REPAIRS & MAINTENANCE	0
		0
		7,728
3	<b>HOUSEKEEPING</b>	
		0
		0
		0
4	<b>LAUNDRY</b>	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	<b>HEAT &amp; OTHER UTILITIES</b>	
	GAS HEAT	39,912
	ELECTRICITY	61,607
	WATER	23,956
	CABLE TV - LOBBY	0
		0
		125,475
6	<b>MAINTENANCE</b>	
	GROUNDS MAINTENANCE	4,879
	PAINTING & DECORATING	0
	BUILDING REPAIRS	43,387
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	0
	ELEVATOR MAINTENANCE & REPAIR	5,684
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,219
	FIRE SERVICE	0
		0
		0
		0
		60,169
7	<b>OTHER</b>	
	SCAVENGER	4,787
	SECURITY SERVICE	0
		4,787
9	<b>MEDICAL DIRECTOR</b>	
	MEDICAL DIRECTOR FEES XVIII B 36-2	36,000
		36,000

LINE	SCHED REF	TOTAL
10	<b>NURSING</b>	
	CONTRACT NURSING XVIII C 53-2	49,058
	LABORATORY & XRAY EXPENSE	2,989
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B -2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	555
	PHARMACY CONSULTANT XVIII B 39-2	0
	UTILIZATION REVIEW FEES XVIII B -2	0
	PHYSICIANS XVIII B -2	0
	PSYCHIATRIC XVIII B -2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		52,602
10a	<b>THERAPY</b>	
	PHYSICAL THERAPY SERVICES	0
	SPEECH THERAPY SERVICES	0
	OCCUPATIONAL THERAPY SERVICES	0
	REHABILITATION CONSULTANT XVIII B -2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTANT XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTANT XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
		0
11	<b>ACTIVITIES</b>	
	CABLE TV - PATIENT ROOMS	0
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	0
		0
		0
		0
12	<b>SOCIAL SERVICES</b>	
	SOCIAL REHABILITATION SERVICES	0
	SOCIAL REHABILITATION CONSULTANT XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	182
		0
		182
13	<b>NURSE AIDE TRAINING</b>	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	<b>PROGRAM TRANSPORTATION</b>	
	PATIENT TRANSPORTATION	419
17	<b>ADMINISTRATIVE</b>	
	MANAGEMENT FEES XIX B	0
18	<b>DIRECTORS FEES</b>	0
19	<b>PROFESSIONAL SERVICES</b>	
	DATA PROCESSING XIX C	29,861
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	26,834
		0
20	<b>FEES,SUBSCRIPTIONS,PROMOTIONS</b>	56,695
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	32,581
	EMPLOYEE WANT ADS XIX F	6,955
	CONTRIBUTIONS VI 20 XIX F	56
	DUES & SUBSCRIPTIONS XIX F	9,991
	LICENSES & PERMITS XIX F	1,838
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	11,137
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	0
21	<b>CLERICAL &amp; GENERAL OFFICE EXPENSES</b>	62,558
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	0
	EQUIPMENT REPAIR & MAINTENANCE	11,569
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	0
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	18,704
	MESSENGER SERVICE	0
		30,273

LINE	SCHED REF	TOTAL
22	<b>EMPLOYEE BENEFITS &amp; PAYROLL TAXES</b>	
	FICA TAXES XIX D	248,361
	UNEMPLOYMENT COMPENSATION XIX D	53,193
	WORKERS COMPENSATION INSURANC XIX D	92,502
	HOSPITALIZATION INSURANCE XIX D	165,052
	EMPLOYEE BENEFITS - OTHER XIX D	8,194
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	9,203
	CHICAGO HEAD TAX XIX D	0
23	<b>INSERVICE TRAINING &amp; EDUCATION</b>	576,505
	EDUCATION & SEMINARS	709
24	<b>TRAVEL &amp; SEMINARS</b>	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	0
		0
		0
25	<b>ADMIN. STAFF TRANSPORTATION</b>	
	TRANSPORTATION - STAFF	1,858
26	<b>INSURANCE - PROP. LIAB &amp; MALPRACTICE</b>	
	GENERAL INSURANCE	181,795
27	<b>OTHER</b>	
	BAD DEBTS VI 24	0
		0

GRAND TOTAL COLUMN 3 OTHER 1,197,755